

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Attorney General



March 10, 2008

BY HAND

The Honorable David A. Catania
Councilmember
Council of the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, DC 20004

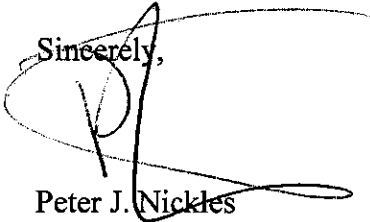
Re: Complaint Against Chartered

Dear David:

The Complaint was filed on Friday. Enclosed is a copy of the Complaint, as well as a letter sent to the Chartered lawyers. I will be meeting with Chartered representatives this morning at their request.

We will be drafting a complaint against Amerigroup and I should have a draft to share with you by midweek. My plan is to file that complaint by the end of the week.

Sincerely,



Peter J. Nickles
Interim Attorney General

Enclosure

cc: David Gragan
JoAnne Ginsberg
Julie Hudman

2008 MAR 17 AM 11:46

COJ/CH/CT/DECATANIA

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE ATTORNEY GENERAL**

**Public Advocacy Division
Civil Enforcement Section**



March 7, 2008

By Fax: (202) 429-0657
Frederick D. Cooke, Jr., Esq.
Rubin, Winston, Diercks, Harris & Cooke, LLP
1155 Connecticut Avenue, NW, Suite 600
Washington, D.C. 20036

By Fax: (202) 420-2201
Seymour Glanzer, Esq.
Dickstein Shapiro, LLP
1825 Eye Street, N.W.
Washington, D.C. 20006-5403

RE: D.C. Chartered Health Plan, Inc.

Gentlemen:

Enclosed is a courtesy copy of the Complaint this Office is filing today against D.C. Chartered Health Plan, Inc. under the D.C. False Claims Act. D.C. Code §§ 2-308.14 and 2-308.15(a).

The Attorney General has prioritized this matter in order to seek an expedited resolution of the District's complaint allegations, which pertain to the determination of capitated rates for August 2006 – July 2007. He recognizes that your client has cooperated with this Office's investigation into this matter. He has asked us to request a meeting with you to see if we can agree on an informal discovery process that would allow the parties to quickly exchange relevant documents and analysis on the issues related to August 2006 – July 2007. We would also discuss a timetable for developing the facts as to other years. As part of this process, we are prepared to agree to a reasonable extension of time to answer the complaint.

If you believe it would be useful, the Attorney General is willing to participate personally in a meeting with you next week. Please call either of the undersigned attorneys to discuss how you wish to proceed.

Frederick D. Cooke, Jr., Esq.
Seymour Glanzer, Esq.
March 7, 2008
Page Two

Sincerely,

PETER J. NICKLES
Interim Attorney General

By: 
BENNETT RUSHKOFF
Senior Division Counsel
Public Advocacy Division
(202) 727-5173


STEPHANIE J. LATOUR
Chief, Civil Enforcement Section
441 4th Street, N.W., Suite 650 North
Washington, D.C. 20001
(202) 727-2430

Enclosure

**SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CIVIL DIVISION**

DISTRICT OF COLUMBIA

441 4th Street, N.W.

Washington, D.C. 20001,

Plaintiff,

v.

D.C. CHARTERED HEALTH

PLAN, INC.

1101 15th Street, N.W., Suite 400

Washington, D.C. 20005,

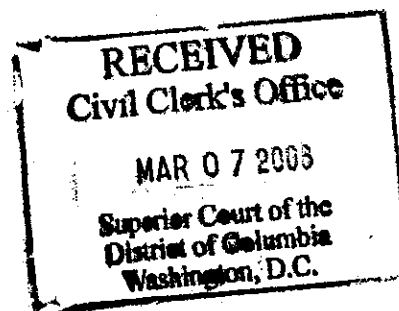
Defendant.

Serve: Nicholas G. Karambelas
1201 PA Ave., N.W., Suite 300
Washington, D.C. 20004

Jeffrey E. Thompson
1101 15th Street, N.W.
Washington, D.C. 20005

JURY TRIAL DEMANDED

Civil Action No.: 0001976-08



COMPLAINT

The District of Columbia, by and through the Office of the Attorney General, its attorneys, pursuant to D.C. Official Code §§ 2-308.14(a) and 2-308.15(a)(2001) and common law, hereby brings suit against D.C. Chartered Health Plan, Inc., and respectfully states as follows:

Jurisdiction

1. This Court has subject matter jurisdiction pursuant to D.C. Official Code §§ 11-921 and 2-308.15 (2001). This Court has personal jurisdiction over the Defendant

pursuant to D.C. Official Code §§ 13-422 and 13-433 (2001).

The Parties

2. Plaintiff District of Columbia (the "District"), a municipal corporation created by an Act of Congress and capable of suing and being sued, is the local government for the district constituting the seat of government of the United States. D.C. Official Code § 1-102 (2001).

3. Defendant D.C. Chartered Health Plan, Inc. ("Chartered") is a corporation incorporated under the laws of the District. Chartered is a Medicaid Managed Care Organization ("MCO") that, among other things, provides health care benefits for Medicaid recipients pursuant to a contract with the District. Approximately 97% of Chartered's revenue was earned from its Medicaid contract with the District in 2006. Chartered is a wholly owned subsidiary of D.C. Healthcare Systems, Inc. ("D.C. Healthcare Systems").

The D.C. False Claims Act

4. The District of Columbia Procurement Reform Act, D.C. Official Code § 2-308.14 (2001) (the "D.C. False Claims Act") provides, in pertinent part:

(a) Any person who commits any of the following acts shall be liable to the District for 3 times the amount of damages which the District sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the District for the costs of a civil action brought to recover penalties or damages, and may be liable to the District for a civil penalty of not less than \$5,000, and not more than \$10,000, for each false claim for which the person:

* * *

(2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false claim paid or approved by the District.

Section 2-308.13(3)(A) of the D.C. False Claims Act defines "Knowing" or "knowingly" to mean:

that a person, with respect to information, does any of the following:

(i) Has actual knowledge of the falsity of the information; (ii) Acts in deliberate ignorance of the truth or falsity of the information; or (iii) Acts in reckless disregard of the truth or falsity of the information.

(B) Proof of specific intent to defraud is not required for an act to be knowing.

The District's Attorney General is expressly authorized by statute to investigate and bring civil actions for treble damages and civil penalties against violations of the D.C. False Claims Act. D.C. Official Code § 2-308.15(a).

The Medicaid Program

5. Medicaid is a joint federal-state program that provides health care services for certain groups, primarily the poor and disabled. The Medicaid program was created in 1965 in Title XIX of the Social Security Act and covers approximately 47 million individuals, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

6. Funding for Medicaid is shared between the federal and state governments, including the District. To qualify for federal funding, state Medicaid programs must provide certain minimum basic services, such as in-patient hospital care to needy individuals. 42 U.S.C. § 1396a. The federal portion of the states' and the District's Medicaid payments, known as the Federal Medical Assistance Percentage, is based on a state's or the District's per capita income compared to the national average. 42 U.S.C. § 1396d(b). In the District, the basic federal contribution is approximately 70 percent, and the District's share is approximately 30 percent.

7. The Department of Health's ("DOH") Medical Assistance Administration ("MAA") is the District agency responsible for administering all Medicaid services authorized by the Social Security Act.

8. The District, as well as all other states, is required to implement a State Health Plan containing specific minimum criteria for coverage and payment of claims. 42 U.S.C. § 1396a(a)(30)(A).

The Medicaid Managed Care Program

9. Since 1981, in order to implement greater cost efficiency within the Medicaid program, the federal government has enabled state Medicaid agencies, including the District, to enter into contracts with MCOs to reduce the costs of the Medicaid programs. To maintain oversight over the Medicaid managed care program, the federal government has devised elaborate statutory regulations that MCOs must comply with in order to receive funding from Medicaid. The Centers for Medicare and Medicaid Services ("CMS") is the federal agency with oversight over the Medicaid program.

10. Federal regulations provide that as a condition for receiving payment under the Medicaid managed care program, an MCO must comply with applicable certification, program integrity, and prohibited affiliation requirements. 42 C.F.R.

§ 438.602. Significantly, when state, or District, payments to an MCO are based on data submitted by the MCO, the state, or District, requires certification of the data by the MCO. 42 C.F.R. § 438.604. Specifically, 42 C.F.R. § 438.604 provides:

(a) *Data Certifications.* When State payments to an MCO . . . are based on data submitted by the MCO . . . , the State must require certification of the data as provided in § 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other

information required by the State and contained in the contracts, proposals, and related documents.

(b) *Additional certifications.* Certification is required, as provided in § 438.606, for all documents specified by the State.

Section 438.606 of 42 C.F.R., *Source, content, and timing of certification*, states:

(a) *Source of certification.* For the data specified in 438.604, the data the MCO . . . submits to the State must be certified by one of the following: (1) The MCO's . . . Chief Executive Officer. (2) The MCO's . . . Chief Financial Officer. (3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's . . . Chief Executive Officer or Chief Financial Officer.

(b) *Content of certification.* The certification must attest, based on best knowledge, information, and belief, as follows: (1) To the accuracy, completeness and truthfulness of the data. (2) To the accuracy, completeness and truthfulness of the documents specified by the State.

(c) *Timing of certification.* The MCO . . . must submit the certification concurrently with the certified data.

In addition, the District's contract with Chartered (the "MCO Contract") cites to these federal regulations regarding certification from an MCO "for any data used by the District to make payments to the [MCO]." The certification must attest that data is accurate, complete, and truthful, and the certification must be submitted concurrently with the certified data. MCO Contract, at H.21.1.

The District's Managed Care Program

11. The District's managed care program was established by the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1993, (D.C. Law 9-247). In April 1994, MAA began operating a managed care program for eligible Medicaid beneficiaries, the D.C. Healthy Families Program ("DCHFP" or the "Medicaid Managed Care program"). Medicaid managed care is mandatory in the District for certain populations; other individuals entitled to Medicaid services may choose either the standard fee-for-service Medicaid program or select from three MCOs. As of January 1,

2007, the Medicaid Managed Care program covered approximately 90,000 of 141,000 District residents eligible for Medicaid.

12. MAA's Office of Managed Care is responsible for planning, setting policies and requirements, developing programs, providing program oversight, and ensuring fiscal accountability for the Medicaid Managed Care program. In turn, each MCO authorizes, monitors, and pays for health care services provided through a network of physicians and other health care providers. In the District, the three MCOs are paid a capitated rate for coordinating health care services for members. As defined by federal regulations, a "[c]apitation payment means a payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment." 42 C.F.R. § 438.2. The amount may be fixed for all members of the MCO or, as in the District, adjusted for the age and gender of groups of members based on actuarial projections of medical utilization.

13. In 2002, the District awarded five-year contracts to each of its current three MCOs; each contract has a base period of one year and option periods for up to four additional years. Contract years for the MCOs cover August 1 through July 31. Pursuant to the MCO contracts, twelve months after the date of the contract award and annually thereafter, the District (or in this case, the District's actuary) must conduct an actuarial review of the capitation rates in effect to determine the actuarial soundness of the rates paid to the MCOs. The actuarial review takes into account factors such as inflation, significant changes in the demographic characteristics of the member population, or

disproportionate enrollment in an MCO by members in certain rate cohorts. This annual review of the capitation rates may result in an upward or downward adjustment to the capitation rates. The annual adjustment becomes effective on the first day of the option period to which the adjusted capitation rate applies.

14. In accordance with federal regulations, MAA has contracted with an actuary, Mercer Government Human Services Consulting ("Mercer"), to conduct the review of the capitation rates and to develop, on an annual basis, actuarially sound capitation rate ranges. See 42 C.F.R. § 438.6. The minimum and maximum capitation rates of these capitation rate ranges developed by Mercer are used by MAA and the District's Office of Contracting and Procurement ("OCP") as required by federal regulations when negotiating contract rates. These rate ranges are not disclosed to the MCOs.

15. Concurrently, the MCOs submit cost proposals to OCP. After discussions regarding the submitted cost proposals are held, OCP submits rates to the MCOs. Individual negotiations are held by MAA and OCP with each MCO, and the rates are accepted or declined by the MCOs. Accepted rates are then submitted to CMS and to the Council of the District of Columbia for approval. If approved, the rates become the next contract year's rates.

Development of the Capitation Rates

16. Each year, pursuant to its contract with the District and in accordance with rate-setting guidelines established by CMS, Mercer develops actuarially sound capitation rate ranges covering the next year's MCO contract period for the District. Since 2003, financial data received from the MCOs have been Mercer's primary source of data for

rate-setting. This financial data reflects the actual medical expenses of each MCO, including its subcapitation payments to providers. Subcapitation is an arrangement whereby an MCO pays its contracted providers on a capitated basis to cover all or some of its services. The financial data includes per member per month medical expenses by major service category for each of the District's rate cells. In the District, there are eleven rate cells for the MCOs; each rate cell is based on age and gender categories and is specific to the District's enrolled population. Mercer develops a rate range for each of these eleven rate cells.

17. Each year, prior to developing the capitation rate ranges, MAA and Mercer send a data request to each participating MCO for financial data, program changes, and other pertinent information that is necessary to develop capitation rate ranges. The data request is generally made in the fall of each year, and the data must be received by MAA and Mercer by January of the next year.

18. The financial data that Mercer receives from the MCOs is certified as accurate in accordance with federal regulations. When each MCO, including Chartered, submits its financial data, it also completes a "DCHFP Data Certification Form" ("Certification"). The Certification is signed by an authorized signatory of the MCO and the MCO's Chief Financial Officer. The Certification states:

I hereby attest that the information submitted in the reports herein is complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable District laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Primary Contractor's contract with the Medical Assistance Administration.

Additionally, I attest in accordance with 42 C.F.R. § 438.604 that the reports have been reviewed and found to be complete, true and accurate to the best of my knowledge, information and belief and have been submitted in accordance with the agreement with the Medical Assistance Administration. I understand that any knowing and willful false statement or representation on the attached data submission may be subject to prosecution under applicable District laws and federal laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement with the Medical Assistance Administration.

19. In order to develop capitation rates for the August 1, 2006 through July 31, 2007 Contract Period, on or about December 16, 2005, Mercer requested financial data from the MCOs for the August 1, 2003 through July 31, 2004 time period and the August 1, 2004 through July 31, 2005 time period. Mercer requested that the MCOs sign and submit a data certification form, certifying that the financial data submitted is complete and accurate. On or about January 20, 2006, Chartered submitted and certified its financial data for these time periods.

Chartered's Related Affiliates

20. Chartered has contracted with MAA to provide health services to Medicaid beneficiaries since approximately 1998. The District awarded Chartered a five-year contract in 2002, to provide health care services to Medicaid beneficiaries. Chartered has provided and continues to provide services to over 38,000 District Medicaid beneficiaries on a yearly basis. Chartered fulfills its MCO contract requirements with the District through approximately 1400 providers, seven hospitals, and 54 primary care sites.

21. The MCO Contract provides that MCOs must report transactions with "Parties of Interest," namely:

In accordance with Section 1903(m)(4)(A), [MCOs] shall report a description of certain transactions with related parties of interest . . . a party of interest is:

- A. Any director, officer, partner, or employee responsible for management or administration of an MCO . . . ; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the MCO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the MCO; or, an incorporator or member of such corporation under applicable District corporation law;
- B. Any organization in which a person is a director, officer or partner, has (directly or indirectly) a beneficial interest of more than 5% of the equity of the MCO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the MCO;
- C. Any person directly or indirectly controlling, controlled by, or under common control with a MCO; or
- D. Any spouse, child, or parent of an individual previously described.

* * *

In accordance with section 1318 of the Public Health Service Act . . . business transactions which shall be disclosed include:

- A. Any sale, exchange, or lease of any property between the MCO and a party in interest;
- B. Any lending of money or other extension of credit between the MCO and a party in interest; and
- C. Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which shall be disclosed for each such transaction includes the name of the party in interest, a description of the transaction and quantity or units involved, the accrued dollar value during the fiscal year, and justification for the reasonableness of the transaction

MCO Contract, at H.23 *et seq.*

22. During fiscal year 2005 and, upon information and belief, in other years, Chartered had a substantial number of financial transactions with companies that were owned by Chartered's parent company or by the parent's President, Chairman of the Board, and sole stockholder. During fiscal year 2005, Chartered spent approximately \$12.2 million of its total \$92.7 million Medicaid contract's operating expenses on

transactions with these affiliated companies. Upon information and belief, Chartered's contracts with these affiliated companies were not negotiated at arm's length. In addition, Chartered's payments to these affiliated companies exceeded amounts that Chartered paid or would have paid to unrelated parties for comparable services.

23. During fiscal year 2005, Chartered also incurred administrative expenses of approximately \$470,000 that did not provide any obvious benefit to the Medicaid program because the expenses consisted of donations to entities. *See id.*, Section II, at p. 4. Administrative expenses, which are considered by MAA and Mercer separately from the financial data used to develop capitation rates, must be expenses related to the administration of the MCO; donations should not be included in administrative expenses.

24. Chartered is wholly owned by D.C. Healthcare Systems. The Chairman of the Board of Directors of Chartered is Jeffrey E. Thompson, who is also the President, Chairman of the Board, and sole stockholder of D.C. Healthcare Systems. Chartered Family Health Center ("CFHC"), a clinic with a provider agreement with Chartered to provide services under the MCO contract, is owned by D.C. Healthcare Systems and governed by the Board of Directors of D.C. Healthcare Systems. RapidTrans, Inc. ("RapidTrans") is a wholly owned subsidiary of D.C. Healthcare Systems and provides all transportation services for Chartered pursuant to the MCO contract. Jeffrey E. Thompson is President and Chairman of the Board of Directors of RapidTrans. Jeffrey E. Thompson is the Chairman, Chief Executive Officer and co-owner of Thompson, Cobb, Bazilio and Associates ("Thompson Cobb"), a consulting firm which performed management consulting for Chartered pursuant to the MCO contract.

Reporting Of Costs From Related Transactions

25. On or about January 20, 2006, Chartered submitted financial data to Mercer and MAA that were certified by Chartered's President and Chief Executive Officer and Chartered's Senior Vice President and Chief Financial Officer as complete, true, and accurate in accordance with the MCO contract provisions and federal regulations. Mercer used this certified financial data as its primary data source in its rate-setting process for the Contract Period August 1, 2006 through July 31, 2007, resulting, upon information and belief, in Chartered obtaining an inappropriately high capitation rate for the Contract Period August 1, 2006 through July 31, 2007. The financial data included improper costs, as described in paragraphs 26-40 below.

CFHC Transactions

26. During calendar year 2005 and, upon information and belief, other years, CFHC, a wholly owned subsidiary of Chartered's parent company, had a provider agreement with Chartered pursuant to the MCO contract. CFHC is one of several primary care providers that Chartered contracts with pursuant to the MCO contract. A primary care provider is a board-certified or board-eligible provider that has a contract with a managed care plan to provide necessary well care, diagnostic, and primary care services, and to manage covered benefits for enrollees. Chartered's contract with CFHC is not different in any significant way from its contracts with other primary care providers. See Milligan & Company, LLC, Report issued on April 2, 2007 ("Milligan Report"), Section I, p. 11, which further details the facts alleged.

27. During calendar year 2005, Chartered paid approximately \$5.5 million to CFHC for services at a subcapitation rate of \$49.44 per member per month. Chartered

paid other primary care providers subcapitation rates that ranged from a high of \$21.50 to a low of \$12.50. These other primary care providers were not related affiliates. *See id.*, Section II, at p. 9.

28. Although Chartered has stated that CFHC provides a “unique set of health services not typically provided by other regular stand alone physician offices and health centers,” Chartered has not adequately documented these unique health services to show that a subcapitation rate of \$49.44 to an affiliated entity is at fair market value. Notably, the subcapitation rate that was calculated for CFHC does not include specialist services or fees that might have accounted for a higher rate. Chartered’s contract with CFHC does not demonstrate that there are any special services provided by CFHC to account for a higher subcapitation rate than other, unrelated, primary care providers. *See id.*, Responses, at pp. 2-3.

29. During calendar year 2005, Chartered also paid approximately \$804,000 to CFHC for health education for Chartered’s Medicaid members as part of the subcapitation rate. These costs, which are included in Chartered’s total medical costs, should not be included in Chartered’s total medical costs. *See id.*, Section II, at p. 9.

30. During calendar year 2005, Chartered also incurred other CFHC expenses, namely the depreciation of leasehold improvements and medical equipment for CFHC. These CFHC expenses, which are included in Chartered’s total medical costs, should not be included in Chartered’s total medical costs. *See id.*, Section I, at p. 11.

31. Upon information and belief, Chartered paid a subcapitation rate to CFHC, a related entity, which exceeded fair market value costs. In addition, Chartered incurred expenses that CFHC, a related affiliate, should have paid. These subcapitation-related

expenses and other expenses should have been discounted in or omitted from Chartered's reported costs.

D.C. Healthcare Systems Transactions

32. During calendar year 2005 and, upon information and belief, other years, D.C. Healthcare Systems, Chartered's parent company, had a management and consulting services contract with Chartered to provide "management and consulting services," pursuant to the MCO contract.

33. During calendar year 2005, Chartered paid approximately \$1.8 million to D.C. Healthcare Systems for consulting services that were provided by the owner of D.C. Healthcare Systems, Jeffrey E. Thompson, and Francis Smith, Senior Vice President and General Counsel of Chartered, and General Counsel of D.C. Healthcare Systems. For calendar year 2004, Thompson provided 2,527 hours at \$198/hour to Chartered for — 50 hr/week management services, totaling \$500,346.00, and for calendar year 2005, Thompson provided 1,842 hours at \$198/hour to Chartered for management services, totaling \$364,716. For calendar year 2004, Smith provided 2,380.5 hours at \$205/hour to — 43 hr/week Chartered for management services, totaling \$488,003.00, and for calendar year 2005, Smith provided 2,364.50 hours at \$205/hour to Chartered for management services, totaling \$484,723. *See id.*, Section II, at p. 10.

34. Chartered's contract with D.C. Healthcare Systems, its parent company, for these "management and consulting services" was not executed until after the year that the costs were actually incurred. The contract states that payments would be based on invoices for services performed. Chartered has not provided any invoices to support these services by its parent company. Chartered has documented these hours with only a

summary of hours per calendar month and an extremely broad descriptions of the nature of the services. *See id.*, Responses, at p. 3. The payments for these services should not have been included in Chartered's reported costs.

RapidTrans Transactions

35. During calendar year 2005 and, upon information and belief, other years, RapidTrans, another wholly owned subsidiary of D.C. Healthcare Systems, was the sole contracted provider of transportation services for Chartered's Medicaid members. Chartered paid a subcapitation rate to RapidTrans for each of its members.

36. The subcapitation rate paid to RapidTrans increased from \$2.95 in fiscal year 2002 to \$5.35 in fiscal year 2005, a dramatic increase of approximately 81% in the subcapitation rate paid to RapidTrans over a three-year period. *See id.*, Section II, at p. 9 and Responses, at p. 3.

37. Chartered states that the \$5.35 subcapitation rate paid to RapidTrans represents fair market value based on its comparison to one other transportation company in the District that provides non-emergency Medicaid transportation services. This same transportation company provides transportation services to another MCO in the District at a subcapitation rate of \$1.70 per member per month. Chartered's subcapitation-related expenses were excessive and should have been discounted in Chartered's reported costs.

38. In addition, Chartered also retroactively applied RapidTrans' 2005 fiscal year subcapitation rate increase to fiscal year 2004, which resulted in approximately \$489,000 in costs charged in fiscal year 2005 for services incurred in fiscal year 2004. These retroactive costs for fiscal year 2004 should not have been included in Chartered's reported costs for fiscal year 2005.

Thompson Cobb Transactions

39. During calendar year 2005 and, upon information and belief, other years, Thompson Cobb, which is co-owned by Jeffrey E. Thompson who is also the Chairman and Chief Executive Officer, performed management consulting services for Chartered. The contract specifies that the services were not to exceed \$845,000. For fiscal year 2005, this contract did not exceed \$845,000, however, the invoices supporting these consulting services do not describe the nature of the services other than "file maintenance review." There is no evidence to show that these services were necessary and that the fees were at fair market value.

40. Upon information and belief, during calendar year 2005, Chartered had approximately \$7.7 million of related party expenses that were excessive, in that they were not compensated at fair market value, or unsupported, in that there was no documentation showing that the services were needed and actually delivered. In addition, during calendar year 2005, Chartered incurred administrative expenses of approximately \$470,000 that did not provide any obvious benefit to the Medicaid program. *See id.*, Section II, at pp. 9-10.

COUNT I

Making Or Using A False Record Or Statement (D.C. Official Code § 2-308.14(a)(2) (2001))

41. The allegations of paragraphs 1 through 40 are realleged as if fully set forth herein.

42. As a condition for receiving payments under the District's Medicaid Managed Care program, Chartered must comply with the applicable certification requirements of 42 C.F.R. § 438.602. The data that must be certified includes

information required by the District and contained in the financial data provided to MAA and the District's actuary on a yearly basis. By submitting and certifying incorrect financial data on or about January 20, 2006, Chartered received a capitation rate set by the District that was inflated. The District would not have paid this inflated capitation rate if it knew that Chartered's financial data was incorrect and its certifications were false.

43. By submitting incorrect financial data and certifying it as accurate, truthful, and complete, Chartered knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the District.

44. For each violation of the D.C. False Claims Act, the District is entitled to recover treble damages from Chartered. *See* D.C. Official Code § 2-308.14(a).

45. In addition, for each violation of the D.C. False Claims Act, the District is entitled to recover from Chartered a civil penalty of not less than \$5,000 and not more than \$10,000 per false claim or false statement. *Id.*

COUNT II

Unjust Enrichment

46. The allegations of paragraphs 1 through 45 are realleged as if fully set forth herein.

47. In connection with the Contract Period August 1, 2006 through July 31, 2007, Chartered has wrongfully obtained property that rightfully belongs to the District.

48. By retaining the District's property to its own use, Chartered has been unjustly enriched to the detriment of the District and, as a result, the District has been

damaged.

WHEREFORE, Plaintiff the District of Columbia respectfully requests this Court to enter judgment in its favor and against Defendant D.C. Chartered Health Plan, Inc., on each of Counts I and II of this Complaint, and impose damages and penalties as follows:

Count I – an amount equal to three times the loss sustained by the District of Columbia Medicaid program, plus penalties of \$10,000 for each false claim or statement;

Count II – an amount equal to the loss sustained by the District of Columbia Medicaid program, plus prejudgment interest.

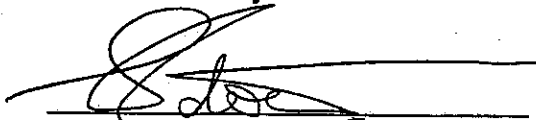
The District of Columbia hereby demands a trial by jury.

Respectfully submitted,

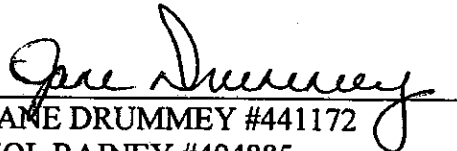
PETER J. NICKLES
Interim Attorney General
for the District of Columbia



BENNETT RUSHKOFF
Senior Division Counsel
Public Advocacy Division



STEPHANE J. LATOUR
Chief, Civil Enforcement Section



JANE DRUMMEY #441172
ZOL RAINEY #494885
Assistant Attorneys General
Office of the Attorney General
441 4th Street, N.W., Suite 650-North
Washington, D.C. 20001

Attorneys for the District of Columbia